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DERMATOLOGY NEW PATIENT MEDICAL HISTORY

Name ____ Date ________________________________

Primary Care Doctor ____________________________

Did your doctor ask you (the patient) to see us or make this appointment? No Yes
If yes, please list your doctor's name and address: ____
____

Reason for today's visit: ____

- How long has the problem been present? ____
- Where is it located? ____
- Symptoms: Bleeding Pain Tingling Itching Scaling Crusting
  Change in Size Change in Color Other __________
- Was a biopsy done? ☐ No ☐ Yes Who did the biopsy? ______________________________
- Are you treating with anything currently? ____
- Any previous treatments? No Yes If yes, what was done and when? ____________________
  ____
- Check all of the following that apply to your (the patient's) risk factors:
  Radiation treatments (not routine x-rays) UV light treatments Arsenic exposure
  Significant outdoor sun exposure Immunosuppression Tanning bed use (current or past?)

Medical History:
Have you (the patient) or any member of your family (specify who) ever had any of the following conditions:

	YOU		**FAMILY MEMBERS**		**WHO?**
	YES	NO	YES	NO	
Asthma					___________
Hay Fever					___________
Eczema					___________
Skin Cancer, including melanoma					___________
Psoriasis					___________
Atypical Moles					___________
Keloids					___________
Lupus					___________

Other Skin Problems: ____
Other forms of cancer:____

Check ALL that apply regarding your (the patient's) medical history and add any other medical problems:

CARDIOVASCULAR	YES	NO
Artificial heart valve		
Pacemaker		
Defibrillator		
High blood pressure		

College Park Family Care Center, P.A.

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Heart attack
Stents
Other heart problems

GASTROINTESTINAL	YES	NO
Colitis		
Celiac disease		

RESPIRATORY	YES	NO
Emphysema		
Asthma		

INFECTIONS	YES	NO
Hepatitis		
Tuberculosis		
Staph infections		
Sexually transmitted infection		
HIV/AIDS		

NEUROLOGICAL	YES	NO
Stroke		
Seizures		
Alzheimer's/dementia		

PSYCHIATRIC	YES	NO
Depression		
Anxiety		
Other emotional/psychiatric problems		

ENDOCRINE	YES	NO
Diabetes		
Thyroid disease		

MUSCULOSKELETAL	YES	NO
Arthritis		
Fibromyalgia		
Artificial joint/Joint replacement		

BLOOD/LYMPH	YES	NO
Anemia		
Bleeding or Clotting disorder		
Leukemia or Lymphoma		

EAR	YES	NO
Hearing aids		

GYNECOLOGIC (females only)	YES	NO
Pregnant		
Nursing		
Currently planning a pregnancy		

What form of birth control do you now use? ____________________

OTHER ____________________

See Reverse

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Review of Systems:
Check **ALL** that apply regarding your (the patient's) overall health:

	YES	NO
Chills		
Fever		
Hives		
Icthing or red eyes		
Dry mouth		
Excessive sweating		
Diarrhea		
Nausea		
Vomiting		
Easy bruising		
Prolonged bleeding		
Muscle aches		
Painful joints		
Headache		
Anxiety		
Depressed Mood		

Social History
- Do you (the patient) smoke cigarettes? Current Past Never If Current, how much? _______
- Does anyone living in your (the patient's home) smoke? Yes No
- Do you (the patient) drink alcohol? Daily Occasionally Never
- Do you (the patient) use sunscreen? Daily Occasionally Never
- What is your (the patient's) occupation?____

Please list medications, dosages, & frequency (include over-the-counter meds, vitamins, supplements, etc.):

Please list allergies:

______________________________ ______________________________ _________________
Signature of Patient or Person Authorized to Sign | Relationship, if other than patient | Date